

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08339

Reg. Dist. No.

8341

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Queen Annes</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Centerville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>JEFFREY ALLAN CAHALL</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>July 13 1958</u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept-11-1915</u>	
<b>9. AGE</b> (In years last birthday) <u>42</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Chesterton Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Elton Noble Cahall</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ellen Cabbage</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> Address <u>Elton N. Cahall Father Centerville Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured knee - hit by auto</u> <u>812X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <u>7/13/58</u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Centerville Md</u>		<b>20f. (City or town)</b> (County) (State) <u>Centerville</u> <u>Queen Anne's</u> <u>MD</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>W. Henry Fisher</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>W HENRY FISHER</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>7/16-58</u>			
<b>22a. BURIAL, CREMATION, or REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>July 16-58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Chestertown</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Centerville Maryland</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. Howard Babin / Babin Bros Centerville Md</u>				<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Centerville</u>	

MEDICAL CERTIFICATION

17

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be retained as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH		TIME OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
DECEASED'S NAME		AGE	
SEX		RACE	
MARRIED		SINGLE	
OCCUPATION		EDUCATION	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
FAMILY HISTORY		SOCIAL HISTORY	
MEDICAL HISTORY		PHYSICAL EXAMINATION	
LABORATORY TESTS		X-RAY EXAMINATION	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
IMPRESSION		REMARKS	

## CERTIFICATE OF DEATH

Reg. Dist. No.

08340

8342

1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>A</u> Last <u>Dorsey</u>				4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-28-87</u>		9. AGE (In years lost birthday) <u>70</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Wright</u>				14. MOTHER'S MAIDEN NAME <u>Ida Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>017-16-1495</u>		17. INFORMANT <u>Bessie Tolson, Stevensville, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral Thrombosis</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis general + cerebral</u> DUE TO (c) <u>Hypertensive Cardio-vascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>July 28, 1958</u> <u>3 years</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Vitiligo many years standing</u> <u>glaucoma both eyes 4 years</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>th</u>		20f. (City or town) (County) (State) <u>th</u>	
21. I certify that I attended the deceased from <u>March 10, 1956</u> to <u>July 29, 1958</u> , that I last saw the deceased alive on <u>July 28, 1958</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmair</u>				ADDRESS (Street, city or town, state) <u>Stevensville md.</u>			
PHYSICIAN'S NAME (Type) <u>THEODOR SATTELMAYER</u>				DATE SIGNED <u>July 30, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville, Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Schell, Eaton, md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8343

## CERTIFICATE OF DEATH

08341

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRICE</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Augusta</u> Last <u>GROSS</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 11 - 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY Wilson</u>		14. MOTHER'S MAIDEN NAME <u>MARY Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-18-4928</u>	
17. INFORMANT <u>EMORY GROSS</u> Address <u>CENTREVILLE, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral (2nd) Vascular Accident</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cordial Vascular Disease</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>June 1958</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerosis Generalized</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 7, 1958</u> , to <u>July 1, 1958</u> , that I last saw the deceased alive on <u>June 28, 1958</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Centreville Md</u> DATE SIGNED <u>July 3, 1958</u>			
ACTUAL SIGNATURE <u>C. R. Layton</u> M.D.			
PHYSICIAN'S NAME (Type) <u>C. R. Layton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 3, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brownsville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Centreville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butler Jr. of Butler Bros., Centreville Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 7 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Quincy</u>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8344

CERTIFICATE OF DEATH

08342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Curtisville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Curtisville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VINCENT</u> Middle <u>HARRIS</u> Last <u>HARRIS</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Celena</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20 - 1893</u>	9. AGE (In years lost birthday) <u>65</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cannery</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Do not know</u>				14. MOTHER'S MAIDEN NAME <u>Do not know</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-07-7109</u>		17. INFORMANT <u>Mamie Harris</u>		Address <u>Curtisville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Paralysis Right Side</u> <u>450.0</u> DUE TO <u>Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>He had auto accident in May</u> DUE TO (c) <u>He had auto accident in May</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 20, 1958</u> to <u>July 7, 1958</u> that I last saw the deceased alive on <u>July 7, 1958</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.F. McHerson</u> M.D.				ADDRESS (Street, city or town, state) <u>Curtisville Md</u> DATE SIGNED <u>7/5/58</u>			
PHYSICIAN'S NAME (Type) <u>H.F. McHerson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 7-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestersfield</u>		22d. LOCATION (City, town, or county) (State) <u>Curtisville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Backus</u> ADDRESS <u>Curtisville Md</u>				24a. REC'D BY REGISTRAR <u>ALL</u> DATE <u>JUL 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>ALL</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

1-28-14

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1869</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Teacher</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. DATE OF DEATH <i>Jan 28 1914</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		12. SIGNATURE OF WITNESSES <i>John Doe, Mary Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF CLERK <i>John Doe</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate is to be signed by the attending physician and completely filled out by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08343

## 8345 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x MILLINGTON R.D. #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SAMUEL</u> First <u>JOHNSON</u> Middle <u>JOHNSON</u> Last		4. DATE OF DEATH <u>JULY 23</u> 19 <u>58</u> Month Day Year	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 2, 1894</u> 63 yrs.
9. AGE (In years last birthday) <u>63</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-16-5079</u>	
17. INFORMANT <u>ETHEL DEMBY</u> Address <u>R.D. #1 MILLINGTON, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anaemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 7</u> , 19 <u>56</u> , to <u>July 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 21</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. H. Hamilton</u>		ADDRESS (Street, city or town, state) <u>MILLINGTON MD.</u> DATE SIGNED <u>JULY 25/58</u>	
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>		<u>MILLINGTON</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PILEYS NECK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>MILLINGTON, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Hellows, Millington, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 28 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>			

1

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08344

8346 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Eliz.</u> Middle <u>King</u> Last		4. DATE OF DEATH <u>July</u> Month <u>6</u> Day <u>1958</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 18-1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. FUNDING YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Queen Anne Co Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Chas Wright</u>		14. MOTHER'S MAIDEN NAME <u>Mary Eliz Handy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>165-14-0469</u>	
17. INFORMANT <u>Hewitt Hollis (daughter)</u>		Address <u>Centerville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/8-58</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>July 8-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Edward Barton</u>		24a. REC'D BY REGISTRAR <u>Barton</u>	
24b. REGISTRAR'S SIGNATURE <u>Centerville Md</u>		DATE <u>JUL 9 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
18828 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*James W. Smith*  
JAMES W. SMITH  
JAMES W. SMITH

*James W. Smith*  
JAMES W. SMITH

1. Name of deceased *James W. Smith*  
2. Age *45*  
3. Sex *Male*  
4. Date of death *Jan 10 1882*  
5. Place of death *at home*  
6. Cause of death *Heart Disease*  
7. Signature of Medical Examiner *James W. Smith*  
8. Signature of Coroner *James W. Smith*  
9. Signature of Physician *James W. Smith*  
10. Signature of Undertaker *James W. Smith*  
11. Signature of Burial Officer *James W. Smith*  
12. Signature of Registrar *James W. Smith*  
13. Signature of Clerk *James W. Smith*  
14. Signature of Treasurer *James W. Smith*  
15. Signature of Assessor *James W. Smith*  
16. Signature of Collector *James W. Smith*  
17. Signature of Surveyor *James W. Smith*  
18. Signature of Engineer *James W. Smith*  
19. Signature of Architect *James W. Smith*  
20. Signature of Painter *James W. Smith*  
21. Signature of Carpenter *James W. Smith*  
22. Signature of Joiner *James W. Smith*  
23. Signature of Blacksmith *James W. Smith*  
24. Signature of Farrier *James W. Smith*  
25. Signature of Coachman *James W. Smith*  
26. Signature of Driver *James W. Smith*  
27. Signature of Porter *James W. Smith*  
28. Signature of Cook *James W. Smith*  
29. Signature of Butler *James W. Smith*  
30. Signature of Valet *James W. Smith*  
31. Signature of Footman *James W. Smith*  
32. Signature of Chamberlain *James W. Smith*  
33. Signature of Steward *James W. Smith*  
34. Signature of Captain *James W. Smith*  
35. Signature of Lieutenant *James W. Smith*  
36. Signature of Major *James W. Smith*  
37. Signature of Colonel *James W. Smith*  
38. Signature of General *James W. Smith*  
39. Signature of Admiral *James W. Smith*  
40. Signature of Captain *James W. Smith*  
41. Signature of Lieutenant *James W. Smith*  
42. Signature of Major *James W. Smith*  
43. Signature of Colonel *James W. Smith*  
44. Signature of General *James W. Smith*  
45. Signature of Admiral *James W. Smith*  
46. Signature of Captain *James W. Smith*  
47. Signature of Lieutenant *James W. Smith*  
48. Signature of Major *James W. Smith*  
49. Signature of Colonel *James W. Smith*  
50. Signature of General *James W. Smith*  
51. Signature of Admiral *James W. Smith*  
52. Signature of Captain *James W. Smith*  
53. Signature of Lieutenant *James W. Smith*  
54. Signature of Major *James W. Smith*  
55. Signature of Colonel *James W. Smith*  
56. Signature of General *James W. Smith*  
57. Signature of Admiral *James W. Smith*  
58. Signature of Captain *James W. Smith*  
59. Signature of Lieutenant *James W. Smith*  
60. Signature of Major *James W. Smith*  
61. Signature of Colonel *James W. Smith*  
62. Signature of General *James W. Smith*  
63. Signature of Admiral *James W. Smith*  
64. Signature of Captain *James W. Smith*  
65. Signature of Lieutenant *James W. Smith*  
66. Signature of Major *James W. Smith*  
67. Signature of Colonel *James W. Smith*  
68. Signature of General *James W. Smith*  
69. Signature of Admiral *James W. Smith*  
70. Signature of Captain *James W. Smith*  
71. Signature of Lieutenant *James W. Smith*  
72. Signature of Major *James W. Smith*  
73. Signature of Colonel *James W. Smith*  
74. Signature of General *James W. Smith*  
75. Signature of Admiral *James W. Smith*  
76. Signature of Captain *James W. Smith*  
77. Signature of Lieutenant *James W. Smith*  
78. Signature of Major *James W. Smith*  
79. Signature of Colonel *James W. Smith*  
80. Signature of General *James W. Smith*  
81. Signature of Admiral *James W. Smith*  
82. Signature of Captain *James W. Smith*  
83. Signature of Lieutenant *James W. Smith*  
84. Signature of Major *James W. Smith*  
85. Signature of Colonel *James W. Smith*  
86. Signature of General *James W. Smith*  
87. Signature of Admiral *James W. Smith*  
88. Signature of Captain *James W. Smith*  
89. Signature of Lieutenant *James W. Smith*  
90. Signature of Major *James W. Smith*  
91. Signature of Colonel *James W. Smith*  
92. Signature of General *James W. Smith*  
93. Signature of Admiral *James W. Smith*  
94. Signature of Captain *James W. Smith*  
95. Signature of Lieutenant *James W. Smith*  
96. Signature of Major *James W. Smith*  
97. Signature of Colonel *James W. Smith*  
98. Signature of General *James W. Smith*  
99. Signature of Admiral *James W. Smith*  
100. Signature of Captain *James W. Smith*

ALL DEATHS MUST BE REPORTED TO THE  
STATE DEPARTMENT OF HEALTH  
WITHIN TEN DAYS OF THE DATE OF DEATH  
AND THE CORPSE MUST BE BURIED  
WITHIN FIVE DAYS OF THE DATE OF DEATH  
UNLESS A PERMIT IS OBTAINED FROM THE  
STATE DEPARTMENT OF HEALTH  
FOR THE INTERMENT OF THE CORPSE  
IN A PRIVATE BURIAL PLACE  
THE STATE DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any. If necessary, please execute the certificate, writing the words "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

1 **B**  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8347 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCH HILL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CHURCH HILL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLARD</u> Middle <u>MOSSMAN</u> Last <u>MOSSMAN</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 26-1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED GEN. SALES MGR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MASS</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>A. E. MOSSMAN</u>		14. MOTHER'S MAIDEN NAME <u>MARY ECOTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. MOSSMAN</u>		Address <u>CHURCH HILL MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Henry Fisher</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7-7-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 8</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. LUKES</u>		22d. LOCATION (City, town, or county) (State) <u>CHURCH HILL MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR <u>W. H. Leach</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	
DATE <u>JUL 10 '58</u>			



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
507 MEDICAL EXAMINER'S CERTIFICATE OF DATA

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. RESIDENCE		6. DATE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH	
10. SIGNATURE OF EXAMINER		11. SIGNATURE OF WITNESS		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JURY		14. SIGNATURE OF JUDGE		15. SIGNATURE OF CLERK	
16. SIGNATURE OF SHERIFF		17. SIGNATURE OF DEPUTY SHERIFF		18. SIGNATURE OF CONSTABLE	
19. SIGNATURE OF JAILER		20. SIGNATURE OF PRISONER		21. SIGNATURE OF WARDEN	
22. SIGNATURE OF CHIEF OF POLICE		23. SIGNATURE OF DETECTIVE		24. SIGNATURE OF PATROLMAN	
25. SIGNATURE OF STREET CARRIER		26. SIGNATURE OF MESSENGER		27. SIGNATURE OF MESSENGER	
28. SIGNATURE OF MESSENGER		29. SIGNATURE OF MESSENGER		30. SIGNATURE OF MESSENGER	
31. SIGNATURE OF MESSENGER		32. SIGNATURE OF MESSENGER		33. SIGNATURE OF MESSENGER	
34. SIGNATURE OF MESSENGER		35. SIGNATURE OF MESSENGER		36. SIGNATURE OF MESSENGER	
37. SIGNATURE OF MESSENGER		38. SIGNATURE OF MESSENGER		39. SIGNATURE OF MESSENGER	
40. SIGNATURE OF MESSENGER		41. SIGNATURE OF MESSENGER		42. SIGNATURE OF MESSENGER	
43. SIGNATURE OF MESSENGER		44. SIGNATURE OF MESSENGER		45. SIGNATURE OF MESSENGER	
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49. SIGNATURE OF MESSENGER		50. SIGNATURE OF MESSENGER		51. SIGNATURE OF MESSENGER	
52. SIGNATURE OF MESSENGER		53. SIGNATURE OF MESSENGER		54. SIGNATURE OF MESSENGER	
55. SIGNATURE OF MESSENGER		56. SIGNATURE OF MESSENGER		57. SIGNATURE OF MESSENGER	
58. SIGNATURE OF MESSENGER		59. SIGNATURE OF MESSENGER		60. SIGNATURE OF MESSENGER	
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64. SIGNATURE OF MESSENGER		65. SIGNATURE OF MESSENGER		66. SIGNATURE OF MESSENGER	
67. SIGNATURE OF MESSENGER		68. SIGNATURE OF MESSENGER		69. SIGNATURE OF MESSENGER	
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97. SIGNATURE OF MESSENGER		98. SIGNATURE OF MESSENGER		99. SIGNATURE OF MESSENGER	
100. SIGNATURE OF MESSENGER		101. SIGNATURE OF MESSENGER		102. SIGNATURE OF MESSENGER	

RECEIVED  
BALTIMORE  
MAY 10 1900

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Item 20 Film 252 7-19-58  
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 16  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08346

8348

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Stevensville</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b> <b>3001-4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>917 S. Fremont Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Samuel Shoulars</b>		4. DATE OF DEATH Month Day Year <b>7 19 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/2/1902</b>
9. AGE (In years last birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BLACKSMITH</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MACHINE MANUFACTURING CO. N.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>CHARLES SHOULARS</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES HARDY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>ALICE SHOULARS</b>		Address <b>917 S. FREMONT</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning - Washed ashore in</b> <b>850X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rent Island</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Boat capsized</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>8:30</b> p. m. <b>7/19/58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>water</b>		20f. (City or town) (County) (State) <b>Chesapeake Bay AA Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>W. O'Leary Fisher</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/29/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall A. Hayes</b>		ADDRESS <b>638 N. GILMOR ST</b>	
24a. REC'D BY REGISTRAR <b>DATE JUL 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Robert Smith</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08347

## 8349 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nr. Sudlersville, Md.</b>		c. LENGTH OF STAY IN 1b <b>years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nr. Sudlersville, Md.</b>		d. STREET ADDRESS <b>1 RFD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At Home</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James A.</b> Middle <b>Simpler</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Kent Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. Simpler</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Amanda Merideth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-20-0247</b>	
17. INFORMANT <b>William Simpler</b>		Address <b>Sudlersville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> (c) <b>Chronic Myocarditis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Smile</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>(u)</b>	
20c. TIME OF INJURY Month <b>20</b> Day <b>19</b> Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 19, 1958</b> , to <b>July 14, 1958</b> , that I last saw the deceased alive on <b>July 12, 1958</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Sudlersville, Md.</b> DATE SIGNED <b>July 14 1958</b> ACTUAL SIGNATURE <b>C. H. Metcalfe</b> M.D. <b>Sudlersville, Md.</b> PHYSICIAN'S NAME (Type) <b>C. H. Metcalfe</b> <b>Sudlersville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 16, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>10 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arden</b>	





1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Queen Anne	STATE	Maryland
CITY (If outside corporate limits, write RURAL or end give nearest town)	Rural Chestertown	COUNTY	Queen Anne
TOWN	Rural Chestertown	CITY (If outside corporate limits, write RURAL and give nearest town)	Rural Chestertown
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Huldah (Middle) Stevens (Last)		(Month) July 12 (Day) 19 (Year) 58	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Fem.	White	Widowed	Mar. 19-1870
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
88 yrs.		Housewife	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Indiana		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Jones		? Bostic	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)			
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
Clayton Stevens--Chestertown, Md.		RD	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) Cardiac Dilatation			
ANTECEDENT CAUSE(S) DUE TO (B) Chronic myocarditis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Aortic Aneurysm			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pericarditis			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
24			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 12, 1958, to July 12, 1958, that I last saw the deceased alive on July 12, 1958, and that death occurred at 1:45 P.M. from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
C. H. Hulse		Luther Hill, Md.	
M.D.		DATE SIGNED 7/14/58	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		July 14	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Crumpton		Crumpton, Maryland	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
JUL 16 '58		Edgar L. Lane	
REGISTRAR'S SIGNATURE		ADDRESS	
Edgar L. Lane		Church Hill, Md.	

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

## CERTIFICATE OF DEATH

REG. CASE NO.

DATE OF DEATH

MARYLAND  
DEPARTMENT OF HEALTH  
BALTIMORE

DECEASED

DECEASED

DECEASED

DECEASED

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ENCLOSURE

NO LATER THAN 10:00 A.M. OF THE DAY FOLLOWING THAT IN WHICH THE DECEASED PERSON WAS FOUND DEAD

SEE INSTRUCTIONS